THE MEDICAL STAFF AND THE HOSPITAL*

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RAY BROWN has described the 20th century hospital as a "three-legged organism without a head"—the three legs being the traditional components of board, administration, and medical staff. He has further stated that this loose organizational structure permitted a comfortable Mexican standoff; each leg could function independently without causing the organization to move in any particular direction.

This worked well until society realized that health care and the right of access to medical care services was no longer a luxury. The very success of medicine in the last 50 years in the ability to cure most diseases and effectively to change the course of many others has made medical care a utilitarian necessity in today's world. This gave society in general and the community at the local level a legitimate role in deciding how, what, when, and where medical services should be delivered.

The community general hospital was also being viewed in a new light. It was becoming a community organization, irrespective of its sponsorship. It was no longer just a facility for acute inpatient care, but the repository of the community's health care resources—both personnel and facilities—the coordinating center, and the one identifiable point of access to medical care.

Consequently the community began to demand that the three-legged organism begin to move in a specific direction to solve the problems of access, safety, cost, and quality. The community began to force action through many separate voices: government—both federal and state; third-party purchases of care—insurance companies, employers, and labor unions; organized consumer groups; and the patients receiving care. To cope with these many external pressures, the organism was

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forced to develop a head—the chief executive officer—not only to be its spokesman but as a conduit for these forces as they exerted their individual constraints on its previously independent action in governance and management.

Unfortunately, in most instances the community general hospital is changing into its new corporate organizational form without one of its former legs: the medical staff. While this is not true of the 400 university-affiliated teaching hospitals where the faculty and medical staff are virtually synonymous—all full-time and on salary—it is basically true of the community general hospitals that provide most hospital care in this country.

Hospitals have not developed a meaningful role for the medical-staff physician in the decision-making processes of the hospital, either in governance or management. A recent study* of hospitals in Illinois and Wisconsin has shown that while medical-staff physicians attending board meetings has increased in the last three years from 47% to 62%, only in 38% of hospitals does the physician have full board membership. Even then this appears to be only a passive role, for only 20% of these physician board members are actively involved in such activities as review of hospital financial statements and developing goals and objectives for the institution. The results of this trend should be obvious; if the hospital develops its new organizational forms excluding the physician from its governance and management, physicians will be forced to deal with the hospital organization simply as another external pressure group through the conduit of the chief executive officer. This will force physicians to create other organizational forms to augment their collective power, already significant; they will either incorporate the medical staff organization, join medical care foundations, or form physician-patient controlled health maintenance organizations (HMOs) which will contract with the hospital for beds and services. Since physicians determine access, utilization, cost, and quality, the control center will be external to the hospital organization.

Despite these possible consequences, this trend in hospital organization appears to be the choice of both a majority of hospital administrators and practicing physicians at this time. Most administrators still believe in the MacEachern Doctrine of the 1930s: that a role for medi-

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cal-staff physicians in hospital governance is a conflict of interest. They also feel that the complexities of modern hospital management are beyond the interest or capabilities of practicing physicians.

Most practicing physicians, whether they are in solo or group practice, still consider themselves individual entrepreneurs. They want to keep it this way for many reasons. The greatest, however, is their basic fear of any organizational structure. This originates from their observation of industrial corporations with an authoritarian management operating in the classical pyramidal, hierarchical structure. They have seen and fear the loss of identity of the individual. Most physicians' service in the military has reinforced this fear; they believe all organizational management is authoritarian. They realize that as professionals they cannot function in this type of environment; and they honestly believe that institutionalization of the practice of medicine, with its constraints on individual freedom, will stifle the creativity and innovation of the professional, destroying the very thing that has made medicine such a success. Where physicians have formed organizational structures for combining their practice, these have been horizontal configurations, using a y-theory of management by peers, where physicians have had a major if not sole voice in their governance.

This is why physicians are demanding a voice in governance as the price for bringing their total practice into the hospital organization. This is why the HMO and HCC development to date has originated from previously existing group practices of physicians—not from hospitals and their medical staff. In fact the only successful hospital-medical staff HCC I have seen developed to date has a board composition of equal components: one third physicians, one third consumers, and one third hospital representatives.

Yet the time has arrived when the self-interest of administrators and physicians must be voluntarily put aside in the best interests of our patients. The great need today is to develop new organizational forms that will assure access to comprehensive health care services in a continuum of care. Physicians alone or hospitals alone cannot accomplish this; it will require a new partnership in a single organizational structure. The hospital of the future must become an organizational entity which combines the special quality of knowledge, skills, and community awareness of its governing board, the organizational expertise and management skills of administration, and the medical knowledge and

skills of the medical staff. It is the combination of these human potentials with the resources of facilities and services and adequate financing that makes possible the delivery of high quality health services.

The present hospital could easily move in this direction by involving the physician in participative management within the organization. But a more pragmatic first step to gain the confidence of the physician is to develop a meaningful role for him in hospital governance. This can be accomplished by providing mechanisms for constant organized medical staff input at the board level in policy determination. This can be accomplished by actual board membership and the use of the joint conference committee, but perhaps *most effectively* by membership on board committees.

However, as hospitals move to a strong executive management, I believe we shall see the board's active role change to one of review and evaluation of management, although retaining its legal, fiduciary, sponsorship, and community-representative functions. When this occurs physicians will have less interest in board membership; they will want to be involved "where the action is"—in management.

The administrative structure must provide maximum freedom for the physician to function as a professional: i.e., he must be free to make independent judgments. I do not believe this will result in the anarchy many administrators fear. I truly believe that *the proper delegation of authority and accountability to a professional creates responsibility in that individual to the organization.* I have seen this work.

How then should the hospital be organized to produce an effective working relation between board, administration, and medical staff? Under law, the hospital organization is given the authority to perform its function for the community and by law, this authority that is, the power to act, and the concomitant accountability to the community for its actions rests with the board. In performing its functions the board must define the organization's goals and objectives to meet these goals and objectives, and assure the quality of all services provided by the hospital organization. These are the major *responsibilities* of the governing board. These *responsibilities* cannot be delegated.

However, the board must delegate authority (i.e., the right to make decisions) and accountability for the actual operation of the institution; *in this sense, governance is extended throughout the entire hospital organization.* This, in turn, creates the *responsibilities* of management.

Management is responsible for the formulation and execution of operating policy, for the efficient use of resources, for the delivery of high-quality health services, and the optimal utilization of these services. *Management in this sense involves both administration and the medical staff*. The medical staff's role in management is the delivery and evaluation of medical care. Administration's role is the creation of the organizational structure to implement policy and provide coordination of the services necessary for the care of patients in support of the medical staff. Management's role in governance is a two-way process; by the *responsible* use of its delegated *authority* it assures implementation of board policy in the operation of the hospital; *its accountability* to the board requires the *responsible* evaluation of operation and the formulation of policy recommendations that will constantly improve the quality of health services. For this process to be effective, it is essential that the delegation of accountability be accompanied by the equal delegation of authority. This delegation of the authority and accountability for the daily operation of the institution is accomplished by the appointment of a chief executive officer, who is the sole individual ultimately accountable to the board for the total operation of the hospital. In this context he could be considered "the board in residence." The chief executive officer, through appropriate delegation of authority and accountability to executive staff and department heads, creates the organizational structure, accountable through him to the board. Where physicians serve as the head of any unit (service or department), they are considered part of the administrative structure of the institution.

This administrative structure provides the mechanism for assuring that formulation of policy does not originate primarily at the board level, but throughout the hospital organization. Recommendations for change in policy should be the product of the problem-solving function of management. Administration should have the primary responsibility for collating policy suggestions and should make specific policy recommendations to the board. The chief executive officer is in the best position to mold all recommendations into specific policy that is compatible with over-all hospital objectives. This does not mean he should make all decisions; the involvement of all personnel in the decision-making process at all levels in the organization has been shown to produce the most effective management, for those involved in policy determination implement policy best in their management roles.